

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0031971</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Greenwood Care Ltd.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>1406 N. Chicago Ave.</u> <u>Evanston</u> <u>60201</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(847) 328-7508</u> Fax # <u>(847) 869-4878</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																									
IDPA ID Number: <u>363487508001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>01/01/90</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
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IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>145</u>	Intermediate (ICF)	<u>145</u>	<u>52,925</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>145</u>	TOTALS	<u>145</u>	<u>52,925</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>48,643</u>	<u>549</u>		<u>49,192</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>48,643</u>	<u>549</u>		<u>49,192</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.95%

D. How many bed-hold days during this year were paid by Public Aid?

1,335 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 02/01/87

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 02/01/87 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning: 01/01/03

Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	137,054	13,259	24,396	174,709		174,709	(13,429)	161,280			1
2	Food Purchase		180,236		180,236	(14,308)	165,928	(20)	165,908			2
3	Housekeeping	138,877	23,450		162,327		162,327	(420)	161,907			3
4	Laundry		12,958	12,227	25,185		25,185		25,185			4
5	Heat and Other Utilities			99,733	99,733		99,733	1,633	101,366			5
6	Maintenance	41,624	23,412	107,636	172,672		172,672	(30,877)	141,795			6
7	Other (specify):*							7,481	7,481			7
8	TOTAL General Services	317,555	253,315	243,992	814,862	(14,308)	800,554	(35,632)	764,922			8
	B. Health Care and Programs											
9	Medical Director			8,100	8,100		8,100		8,100			9
10	Nursing and Medical Records	824,683	19,788	87,534	932,005		932,005	(15,677)	916,328			10
10a	Therapy			15,516	15,516		15,516	(5,357)	10,159			10a
11	Activities	119,469	10,382	1,000	130,851		130,851		130,851			11
12	Social Services	207,371			207,371		207,371		207,371			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,880	4,880			15
16	TOTAL Health Care and Programs	1,151,523	30,170	112,150	1,293,843		1,293,843	(16,154)	1,277,689			16
	C. General Administration											
17	Administrative	62,717		363,738	426,455		426,455	(254,184)	172,271			17
18	Directors Fees											18
19	Professional Services			124,189	124,189	(74)	124,115	(85,765)	38,350			19
20	Dues, Fees, Subscriptions & Promotions			25,468	25,468		25,468	(6,172)	19,296			20
21	Clerical & General Office Expenses	126,904	18,838	44,688	190,430		190,430	36,072	226,502			21
22	Employee Benefits & Payroll Taxes			260,546	260,546	14,308	274,854	(327)	274,527			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,683	2,683		2,683	366	3,049			24
25	Other Admin. Staff Transportation			1,696	1,696		1,696	2,145	3,841			25
26	Insurance-Prop.Liab.Malpractice			123,060	123,060		123,060	858	123,918			26
27	Other (specify):*							24,663	24,663			27
28	TOTAL General Administration	189,621	18,838	946,068	1,154,527	14,234	1,168,761	(282,344)	886,417			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,658,699	302,323	1,302,210	3,263,232	(74)	3,263,158	(334,130)	2,929,028			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Greenwood Care Ltd.

#0031971

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			39,637	39,637		39,637	138,985	178,622			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							326,747	326,747			32
33	Real Estate Taxes			123,126	123,126	74	123,200	4,624	127,824			33
34	Rent-Facility & Grounds			476,280	476,280		476,280	(476,280)				34
35	Rent-Equipment & Vehicles			14,498	14,498		14,498	4,850	19,348			35
36	Other (specify):*							8,459	8,459			36
37	TOTAL Ownership			653,541	653,541	74	653,615	7,385	661,000			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,387	79,387		79,387		79,387			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			79,387	79,387		79,387		79,387			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,658,699	302,323	2,035,138	3,996,160		3,996,160	(326,745)	3,669,415			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	59,170	30		9
10	Interest and Other Investment Income	(19,097)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,440)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(956)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(30,395)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 5,262		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(332,007)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (332,007)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (326,745)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Year: 0031971
Report Period Beginning: 01/01/03
Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	IL Council on LTC - COPE Dues	\$ (1,976)	20 1
2	State Replacement Tax	(5,803)	21 2
3	Theft & Damage	(678)	23 3
4	Capitalized RAM	(13,543)	06 4
5	Legal (Prior Year & Non-Allowable)	(7,879)	19 5
6	Miscellaneous Income	(276)	23 6
7	Architect Fees	(1,840)	19 7
8			8
9			9
10			10
11			11
12			12
13			13
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93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(30,395)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(13,429)							(13,429)	1
2	Food Purchase	(20)											(20)	2
3	Housekeeping			493				(913)					(420)	3
4	Laundry													4
5	Heat and Other Utilities			635	998								1,633	5
6	Maintenance	(13,543)		501	(8,307)	(9,528)							(30,877)	6
7	Other (specify):*				744	6,737							7,481	7
8	TOTAL General Services	(13,563)		1,629	(6,565)	(16,220)		(913)					(35,632)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(13,295)			(2,382)					(15,677)	10
10a	Therapy					(5,357)							(5,357)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,281	1,599							4,880	15
16	TOTAL Health Care and Programs				(10,014)	(3,758)		(2,382)					(16,154)	16
	C. General Administration													
17	Administrative			12,202	(44,245)	(222,141)							(254,184)	17
18	Directors Fees													18
19	Professional Services	(8,919)		(72,183)	(11,568)	6,905							(85,765)	19
20	Fees, Subscriptions & Promotions	(6,372)		141	59								(6,172)	20
21	Clerical & General Office Expenses	(5,957)	39	40,305	1,685								36,072	21
22	Employee Benefits & Payroll Taxes						(327)						(327)	22
23	Inservice Training & Education													23
24	Travel and Seminar			119	247								366	24
25	Other Admin. Staff Transportation			554	1,591								2,145	25
26	Insurance-Prop.Liab.Malpractice			280	578								858	26
27	Other (specify):*			7,172	2,471	15,020							24,663	27
28	TOTAL General Administration	(21,248)	39	(11,410)	(49,182)	(200,216)	(327)						(282,344)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,811)	39	(9,781)	(65,761)	(220,194)	(327)	(3,295)					(334,130)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	59,170	75,775	1,769	2,271								138,985	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(19,097)	343,355	482	2,007								326,747	32
33	Real Estate Taxes			1,628	2,996								4,624	33
34	Rent-Facility & Grounds		(476,280)										(476,280)	34
35	Rent-Equipment & Vehicles			1,594	3,256								4,850	35
36	Other (specify):*		8,459										8,459	36
37	TOTAL Ownership	40,073	(48,691)	5,473	10,530								7,385	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	5,262	(48,652)	(4,308)	(55,231)	(220,194)	(327)	(3,295)					(326,745)	45

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached				Greenwood Care LLC	Evanston	Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rental Income	\$ 476,280	Greenwood Care LLC	100.00%	\$	\$ (476,280)
2	V	32 Interest Income	24	Greenwood Care LLC			(24)
3	V	30 Depreciation-Base		Greenwood Care LLC		72,192	72,192
4	V	30 Depreciation - Sec. 754		Greenwood Care LLC		3,583	3,583
5	V	32 Interest Expense		Greenwood Care LLC		343,379	343,379
6	V	21 Office Expense		Greenwood Care LLC		9	9
7	V	21 Filing Fees		Greenwood Care LLC		30	30
8	V	36 Amortization Loan Fees		Greenwood Care LLC		8,439	8,459
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 476,304			\$ 427,632	\$ * (48,652)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 493	\$ 493
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	635	635
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	501	501
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	12,202	12,202
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,557	1,557
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	141	141
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	40,305	40,305
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	119	119
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	554	554
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	280	280
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	7,172	7,172
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,769	1,769
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	482	482
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,628	1,628
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	1,594	1,594
30	V						
31	V						
32	V	19 ACCOUNT./BOOKKEEPING	73,740	PREFERRED BOOKKEEPING	100.00%		(73,740)
33	V	19 COMPUTER	3,480	PREFERRED BOOKKEEPING	100.00%	3,480	
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 77,220			\$ 72,912	\$ * (4,308)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 998	\$ 998	15
16	V	6 REPAIRS AND MAINT.	13,056	S.I.R. MANAGEMENT, INC.	100.00%	4,749	(8,307)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	744	744	17
18	V	10 NURSING	28,716	S.I.R. MANAGEMENT, INC.	100.00%	15,421	(13,295)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,281	3,281	19
20	V	17 ADMINISTRATIVE	50,868	S.I.R. MANAGEMENT, INC.	100.00%	6,623	(44,245)	20
21	V	19 PROFESSIONAL FEES	11,748	S.I.R. MANAGEMENT, INC.	100.00%	180	(11,568)	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	59	59	22
23	V	21 CLERICAL & GENERAL	14,796	S.I.R. MANAGEMENT, INC.	100.00%	16,481	1,685	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	247	247	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	1,591	1,591	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	578	578	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,471	2,471	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,271	2,271	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	2,007	2,007	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,996	2,996	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,256	3,256	31
32	V							32
33	V	35 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%			33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%			34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 119,184			\$ 63,953	\$ * (55,231)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 14,796	S.I.R. MANAGEMENT, INC.	100.00%	\$ 4,864	\$ (9,932)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,035	1,035	16
17	V	17	ADMIN./LEGAL SALARIES	297,270	S.I.R. MANAGEMENT, INC.	100.00%	40,087	(257,183)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	10,385	10,385	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	6,031	6,031	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	26,826	26,826	21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,545	4,545	22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	23,816	23,816	24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,444	4,444	25
26	V								26
27	V	10A	SPECIAL REHAB	12,876	S.I.R. MANAGEMENT, INC.	100.00%	7,519	(5,357)	27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,599	1,599	28
29	V								29
30	V	6	REPAIRS AND MAINT.	30,204	S.I.R. MANAGEMENT, INC.	100.00%	20,676	(9,528)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	4,398	4,398	31
32	V								32
33	V	1	DIETICIAN SALARIES	9,600	S.I.R. MANAGEMENT, INC.	100.00%	6,103	(3,497)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,304	1,304	34
35	V								35
36	V	19	LEGAL FEES	3,480	S.I.R. MANAGEMENT, INC.	100.00%		(3,480)	36
37	V								37
38	V	17	COUNCIL DUES	15,600	S.I.R. MANAGEMENT, INC.	100.00%		(15,600)	38
39	Total			\$ 383,826			\$ 163,631	\$ * (220,194)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 77,510	\$ 77,510	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	77,837	CCS EMPLOYEE BENEFIT GROUP	100.00%		(77,837)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 77,837			\$ 77,510	\$ * (327)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING	6,935	XCEL MEDICAL SUPPLY, LLC	100.00%	6,022	(913)	17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10 NURSING	18,095	XCEL MEDICAL SUPPLY, LLC	100.00%	15,713	(2,382)	20
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 25,030			\$ 21,735	\$ * (3,295)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nenita Guzman	Relative	Dietary	0%	See Attached	3.83	7.66%	Alloc. SIR	\$ 4,864	01-07	1
2	Louise Bergthold	Shareholder	Administrative	3.45%	See Attached	4.22	7.67%	Alloc. SIR	13,665	17-7	2
3	Thomas Winter	Owner	Administrative	4.08%	See Attached	4.73	7.88%	Alloc. SIR	12,202	17-7	3
4	Adam Vales	Relative	Clerical	0%	See Attached	0.40	1.00%	Alloc. SIR	310	22-7	4
5	Bryan Barrish	Owner	Administrative	4.83%	See Attached	4.72	11.80%	Alloc. SIR	26,826	17-7	5
6	Michael Giannini	Owner	Administrative	3.45%	See Attached	4.72	11.80%	Alloc. SIR	23,816	17-7	6
7	Eric Rothner	Owner	Administrative	51.72%	See Attached	0.42	0.76%	Alloc. SIR	11,060	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,743		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PREFERRED BOOKKEEPING SERVICES
 Street Address 4100 WEST PRATT AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 674-5200
 Fax Number (847) 674-5267

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	935,658	11	\$ 6,250	\$ 73,740	\$ 493	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	935,658	11	8,058	73,740	635	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	935,658	11	6,361	73,740	501	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	935,658	11	154,828	73,740	12,202	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	935,658	11	19,761	73,740	1,557	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	935,658	11	1,793	73,740	141	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	935,658	11	511,408	73,740	40,305	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	935,658	11	1,508	73,740	119	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	935,658	11	7,028	73,740	554	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	935,658	11	3,553	73,740	280	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	935,658	11	91,005	73,740	7,172	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	935,658	11	22,443	73,740	1,769	12
13	32	INTEREST	BOOK./ACCNT.INCOME	935,658	11	6,117	73,740	482	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	935,658	11	20,656	73,740	1,628	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	935,658	11	20,229	73,740	1,594	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					3,480	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 880,998	\$ 608,675	\$ 72,912	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 675 -7979Fax Number (847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	641,706	10	\$ 13,016	\$	49,192	\$ 998	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	641,706	10	61,951		49,192	4,749	2
3	7 EMP. BEN.-GEN. SERV.	PATIENT DAYS	641,706	10	9,705		49,192	744	3
4	10 NURSING	PATIENT DAYS	641,706	10	201,162	201,162	49,192	15,421	4
5	15 EMP. BEN.-H.C.	PATIENT DAYS	641,706	10	42,801		49,192	3,281	5
6	17 ADMINISTRATIVE	PATIENT DAYS	641,706	10	86,401	86,401	49,192	6,623	6
7	19 PROFESSIONAL FEES	PATIENT DAYS	641,706	10	2,349		49,192	180	7
8	20 FEES,SUBSCRIPTIONS	PATIENT DAYS	641,706	10	773		49,192	59	8
9	21 CLERICAL & GENERAL	PATIENT DAYS	641,706	10	214,995	167,138	49,192	16,481	9
10	24 EDUCATION & SEMINAR	PATIENT DAYS	641,706	10	3,219		49,192	247	10
11	25 OTHER ADMIN. STAFF TRANS	PATIENT DAYS	641,706	10	20,755		49,192	1,591	11
12	26 INSURANCE	PATIENT DAYS	641,706	10	7,541		49,192	578	12
13	27 EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	641,706	10	32,233		49,192	2,471	13
14	30 DEPRECIATION	PATIENT DAYS	641,706	10	29,623		49,192	2,271	14
15	32 INTEREST	PATIENT DAYS	641,706	10	26,178		49,192	2,007	15
16	33 REAL ESTATE TAXES	PATIENT DAYS	641,706	10	39,087		49,192	2,996	16
17	35 EQUIPMENT RENTAL	PATIENT DAYS	641,706	10	42,473		49,192	3,256	17
18									18
19	35 LEASED EQUIPMENT	LEASING INCOME	24,090	1					19
20	30 DEPRECIATION	LEASING INCOME	24,090	1	91,098				20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 925,360	\$ 500,323		\$ 63,953	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 675 -7979Fax Number (847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	DIETARY SALARIES	PATIENT DAYS	641,706	10	\$ 63,448	\$ 63,448	49,192	\$ 4,864	1
2	EMP. BEN.-DIETARY	PATIENT DAYS	641,706	10	13,496		49,192	1,035	2
3	ADMIN./LEGAL SALARIES	PATIENT DAYS	641,706	10	522,936	522,936	49,192	40,087	3
4	FINANCIAL CONSULTANT	PATIENT DAYS	641,706	10	135,472		49,192	10,385	4
5	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	641,706	10	\$ 78,674	\$	49,192	\$ 6,031	5
6									6
7	17 ADMIN. SALARY	AVG HRS WKD	30	4	170,502	170,502	5	26,826	7
8	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	4	28,886		5	4,545	8
9					\$	\$		\$	9
10	17 ADMIN SALARY	AVG HRS WKD	30	4	151,372	151,372	5	23,816	10
11	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	4	28,244		5	4,444	11
12									12
13	10A SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 62,910	\$ 62,910	12,876	\$ 7,519	13
14	15 EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	107,736	7	13,382		12,876	1,599	14
15									15
16	6 REPAIRS AND MAINT.	MAINTENANCE INC.	163,332	10	111,809	111,809	30,204	20,676	16
17	7 EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	163,332	10	23,783		30,204	4,398	17
18									18
19	1 DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	79,717	79,717	9,600	6,103	19
20	7 EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	17,031		9,600	1,304	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,501,663	\$ 1,162,695		\$ 163,631	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 77,510	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 77,510	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLCStreet Address 2201 MAIN STREETCity / State / Zip Code EVANSTON, IL 60202Phone Number (847)328-7600Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 DIETARY	Direct Allocation			\$	\$		\$	1
2	02 FOOD	Direct Allocation							2
3	03 HOUSEKEEPING	Direct Allocation						6,022	3
4	04 LAUNDRY	Direct Allocation							4
5	06 REPAIRS & MAINTENANCE	Direct Allocation							5
6	10 NURSING	Direct Allocation						15,713	6
7	10A THERAPY	Direct Allocation							7
8	12 SOCIAL SERVICE	Direct Allocation							8
9	21 CLERICAL & GENERAL OFFICE	Direct Allocation							9
10	22 EMPLOYEE BENEFITS	Direct Allocation							10
11	39 ANCILLARY	Direct Allocation							11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 21,735	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Normura		X	Mortgage	\$35,561.00	03/01/95	\$	3,856,786	02/01/21	8.69%	\$	343,379	1	
2													2	
3													3	
4													4	
5	See Supplemental Schedule												5	
	Working Capital													
6	Alloc. SIR Mangement		X									2,007	6	
7	Alloc. Preferred Bookkeeping		X									482	7	
8	See Supplemental Schedule												8	
9	TOTAL Facility Related				\$35,561.00		\$	3,856,786				\$	345,868	9
	B. Non-Facility Related*													
10													10	
11	Interest Income (Bldg Co)		X									(24)	11	
12	Interest Income		X									(19,097)	12	
13	See Supplemental Schedule												13	
14	TOTAL Non-Facility Related						\$					\$	(19,121)	14
15	TOTALS (line 9+line14)						\$	3,856,786				\$	326,747	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0.00 Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-18-324-019-000</u>	<u>Long Term Care Property</u>	\$ <u>121,326.44</u>	\$ <u>121,326.44</u>
2. <u>SIR/Preferred Bookkeeping Alloc</u>	<u>See Attached</u>	\$ <u>74,287.87</u>	\$ <u>2,898.16</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>195,614.31</u>	\$ <u>124,224.60</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A.

Square Feet:

32,467

B.

General Construction Type:

Exterior

Brick

Frame

7

Number of Stories

C.

Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility-Greenwood Care LLC		1987	\$ 152,555	1
2					2
3	TOTALS			\$ 152,555	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/03

Ending:

12/31/03

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1984		2,672		20	76	76	1,344	9
10	Various		1987		24,869		20	723	723	12,784	10
11	Various		1988		27,733		20	1,146	1,146	13,145	11
12	Various		1989		21,624		20	1,016	(1,016)	12,186	12
13	Various		1990		27,300		20	1,365	1,365	19,747	13
14	Various		1991		9,846		20	491	491	6,907	14
15	Various		1992		25,025		20	1,244	1,244	15,033	15
16	Various		1993		63,911		20	3,195	3,195	34,356	16
17	Various		1994		20,319		20	1,017	1,017	9,540	17
18	Various		1995		73,839		20	3,693	3,693	31,724	18
19	Various		1996		109,220		20	5,461	5,461	41,238	19
20	Various		1997		73,171		20	3,658	3,658	23,803	20
21	Various		1998		58,371		20	2,919	2,919	15,990	21
22	Various		1999		192,299		20	9,617	9,617	40,118	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,845,500	75,775		90,024	14,249	1,001,679	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		63,854	2,180		2,522	342	21,469	68
69	Financial Statement Depreciation			3,489			(3,489)		69
70	TOTAL (lines 4 thru 69)		\$ 2,639,553	\$ 81,444		\$ 128,167	\$ 44,691	\$ 1,301,063	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

****Improvement type must be detailed in order for the cost report to be considered complete.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,954,977	\$ 81,444		\$ 144,473	\$ 63,029	\$ 1,346,862	1
2	Fire Door	2003	3,905		20	49	49	49	2
3	Bathroom Work	2003	6,300		20	53	53	53	3
4	Bathroom Work	2003	2,250		20	19	19	19	4
5	Elevator Work	2003	4,400		20	37	37	37	5
6	Boiler Work	2003	10,800		20	90	90	90	6
7	Boiler Work	2003	4,132		20	52	52	52	7
8	Alarm Work	2003	1,043		20	4	4	4	8
9	Floor & Tile	2003	4,385		20	110	110	110	9
10	Drain Pipe	2003	640		20	21	21	21	10
11	Motor & Pump	2003	1,493		20	25	25	25	11
12	Drain Pipe	2003	1,765		20	44	44	44	12
13	Paint	2003	1,759		20	44	44	44	13
14	Tile	2003	1,491		20	87	87	87	14
15	Tile	2003	588		20	29	29	29	15
16	Architect	2003	1,040		20	104	104	104	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated		
Constructed			Depreciation	in Years	Depreciation		Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630		34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,000,968	\$ 81,444		\$ 145,241	\$ 63,797	\$ 1,347,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145			1990	\$ 1,845,500	\$ 75,775		\$ 90,024	\$ 14,249	\$ 1,001,679	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$		70
		1,845,500	75,775		90,024	14,249	1,001,679		

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	SIR		1993	\$ 20,484	\$ 650	35	\$ 585	\$ (65)	\$ 6,145
5	SIR		1993	11,129	353	35	318	(35)	3,339
6									
7									
8									
Improvement Type**									
9	Allocation SIR Management		1993	8,798	245	20	443	198	4,798
10	Allocation SIR Management		1994	27	-	20	3	3	26
11	Allocation SIR Management		1995	201	-	20	10	10	85
12	Allocation SIR Management		1999	956	-	20	48	(48)	201
13	Allocation SIR Management		2000	577	-	20	29	29	106
14									
15	Allocation SIR Properties - Preferred Bookkeeping		1993	180	3	20	9	6	95
16	Allocation SIR Properties - Preferred Bookkeeping		1994	106	3	20	5	2	50
17	Allocation SIR Properties - Preferred Bookkeeping		1997	42	4	20	2	(2)	16
18	Allocation SIR Properties - Preferred Bookkeeping		1998	674	67	20	34	(33)	185
19	Allocation SIR Properties - Preferred Bookkeeping		1999	1,410	141	20	71	(70)	317
20	Allocation SIR Properties - Preferred Bookkeeping		2002	44	-	20	2	2	3
21									
22	Allocation SIR Properties - SIR Management		1993	332	5	20	17	12	175
23	Allocation SIR Properties - SIR Management		1994	195	5	20	10	5	93
24	Allocation SIR Properties - SIR Management		1997	77	8	20	4	(4)	29
25	Allocation SIR Properties - SIR Management		1998	1,240	125	20	62	(63)	341
26	Allocation SIR Properties - SIR Management		1999	2,596	260	20	130	(130)	584
27	Allocation SIR Properties - SIR Management		2002	81	-	20	4	4	6
28									
29	Allocation Preferred Bookkeeping		1997	13,898	311	20	695	384	4,731
30	Allocation Preferred Bookkeeping		1999	110	-	20	6	6	25
31	Allocation Preferred Bookkeeping		2000	697	-	20	35	35	119
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 63,854	\$ 2,180		\$ 2,522	\$ 246	\$ 21,469	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 480,813	\$ 37,651	\$ 33,150	\$ (4,501)	10	\$ 325,319	71
72	Current Year Purchases	4,860	357	231	(126)	10	231	72
73	Fully Depreciated Assets	30,803				10	30,803	73
74								74
75	TOTALS	\$ 516,476	\$ 38,008	\$ 33,381	\$ (4,627)		\$ 356,353	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,669,999	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,452	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,622	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 59,170	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,703,983	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 7,874 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Chevy Van	\$ 551.99	\$ 6,624	17
18	Alloc Sir Management			3,256	18
19	Alloc Pref. Bkpping			1,594	19
20					20
21	TOTAL		\$ 551.99	\$ 11,474	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 26,978	\$ 29,365	1
2	Cash-Patient Deposits	11,634	11,634	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	491,616	491,616	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,425	13,425	6
7	Other Prepaid Expenses	5,675	5,675	7
8	Accounts Receivable (owners or related parties)	490,000	490,000	8
9	Other(specify): See Attached Schedule	51,598	51,598	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,090,926	\$ 1,093,313	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	569,850	569,850	15
16	Equipment, at Historical Cost	705,164	924,526	16
17	Accumulated Depreciation (book methods)	(740,851)	(1,882,818)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		101,513	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(66,615)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	14,167	38,595	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 548,330	\$ 2,111,668	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,639,256	\$ 3,204,981	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 90,719	\$ 90,717	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,390	14,390	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	141,518	141,518	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,751	8,751	31
32	Accrued Real Estate Taxes(Sch.IX-B)	124,800	124,800	32
33	Accrued Interest Payable		19,551	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,750	4,750	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	23,010	23,010	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 407,938	\$ 427,487	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,856,786	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,856,786	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 407,938	\$ 4,284,273	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,231,318	\$ (1,079,292)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,639,256	\$ 3,204,981	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,242,260	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,242,260	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	308,058	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(319,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (10,942)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,231,318	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,283,546	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,283,546	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,097	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,097	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,575	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,575	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,304,218	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	814,862	31
32	Health Care	1,293,843	32
33	General Administration	1,154,527	33
	B. Capital Expense		
34	Ownership	653,541	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	79,387	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,996,160	40
41	Income before Income Taxes (line 30 minus line 40)**	308,058	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 308,058	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Greenwood Care Ltd.# 0031971Report Period Beginning: 01/01/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,997	2,085	\$ 50,653	\$ 24.29	1
2	Assistant Director of Nursing	1,481	1,596	37,670	23.60	2
3	Registered Nurses	619	627	13,044	20.80	3
4	Licensed Practical Nurses	11,391	11,953	233,699	19.55	4
5	Nurse Aides & Orderlies	47,194	50,073	462,132	9.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,706	4,164	48,066	11.54	9
10	Activity Assistants	9,399	10,193	71,403	7.01	10
11	Social Service Workers	15,483	16,941	207,371	12.24	11
12	Dietician	1,973	2,086	26,430	12.67	12
13	Food Service Supervisor					13
14	Head Cook	5,646	5,854	41,510	7.09	14
15	Cook Helpers/Assistants	9,347	9,828	69,114	7.03	15
16	Dishwashers					16
17	Maintenance Workers	4,293	4,637	41,624	8.98	17
18	Housekeepers	16,253	17,411	138,877	7.98	18
19	Laundry					19
20	Administrator	1,839	2,086	62,717	30.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,581	15,630	126,904	8.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,303	2,564	27,485	10.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	147,505	157,728	\$ 1,658,699 *	\$ 10.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fee	\$ 9,600	01-03	35
36	Medical Director	Monthly Fee	8,100	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant	Monthly Fee	28,716	10-03	38
39	Pharmacist Consultant	Monthly Fee	1,454	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly Fee	2,640	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,000	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Specialized Rehab	Monthly	12,876	10a-03	47
48	Director of Food Services	Monthly	14,796	01-03	48
49	TOTAL (lines 35 - 48)	116	\$ 83,310		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,024	\$ 53,236	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,024	\$ 53,236		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.# 0031971Report Period Beginning: 01/01/03Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount		
<u>Del Rychener</u>	<u>Administrator</u>	<u>0</u>	\$ <u>62,717</u>	<u>Workers' Compensation Insurance</u>	\$ <u>16,704</u>	<u>IDPH License Fee</u>	\$ <u>3,589</u>		
				<u>Unemployment Compensation Insurance</u>	<u>14,906</u>	<u>Advertising: Employee Recruitment</u>	<u>3,589</u>		
				<u>FICA Taxes</u>	<u>125,067</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>54,784</u>	<u>(Indicate # of checks performed <u>20</u>)</u>	<u>196</u>		
				<u>Employee Meals</u>	<u>14,308</u>	<u>Advertising & Promotion</u>	<u>956</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>5,463</u>		
				<u>Union Health & Welfare</u>	<u>40,762</u>	<u>Licenses & Fees</u>	<u>9,300</u>		
				<u>401K Plan</u>	<u>6,050</u>	<u>Permits</u>	<u>548</u>		
				<u>Employee Benefits Other</u>	<u>1,946</u>	<u>Allocation Preferred Bookkeeping</u>	<u>141</u>		
						<u>See Supplemental Schedule</u>	<u>59</u>		
						<u>Less: Public Relations Expense</u>	<u>()</u>		
						<u>Non-allowable advertising</u>	<u>(956)</u>		
						<u>Yellow page advertising</u>	<u>()</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>62,717</u>	TOTAL (agree to Schedule V,	\$ <u>274,528</u>	TOTAL (agree to Sch. V,	\$ <u>19,296</u>		
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount	
<u>Management Fees - SIR Management</u>			\$ <u>297,270</u>				<u>Out-of-State Travel</u>	\$ <u> </u>	
<u>Ancillary Admin</u>			<u>32,592</u>						
<u>Extended Care Mangement - Council Dues</u>			<u>15,600</u>				<u>In-State Travel</u>		
<u>See Supplemental Schedule</u>			<u>18,276</u>						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>363,738</u>						
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	<u>2,683</u>	
C. Professional Services							<u>Allocation Preferred Bookkeeping</u>	<u>119</u>	
Vendor/Payee	Type		Amount				<u>Allocation SIR Management</u>	<u>247</u>	
<u>FR&R</u>	<u>Accounting</u>		\$ <u>12,542</u>				<u>Entertainment Expense</u>	<u>()</u>	
<u>ICS Solutions</u>	<u>Computer</u>		<u>90</u>				TOTAL	(agree to Sch. V,	
<u>LTC Solutions</u>	<u>Computer</u>		<u>1,320</u>				line 24, col. 8)	\$ <u>3,049</u>	
<u>Personnel Planners</u>	<u>Unemployment Consulting</u>		<u>1,174</u>						
<u>SAS Architects</u>	<u>Architects Fees</u>		<u>1,040</u>						
<u>Akin Gump Strauss Hauer</u>	<u>Legal</u>		<u>735</u>						
<u>Foley & Lardner</u>	<u>Legal</u>		<u>5,027</u>						
<u>Stone, McGuire, Benjamin</u>	<u>Legal</u>		<u>3,110</u>						
<u>Michael Best & Friedrich</u>	<u>Legal</u>		<u>6,703</u>						
<u>Preferred Bookkeeping</u>	<u>Bookkeeping</u>		<u>45,240</u>						
<u>Preferred Bookkeeping</u>	<u>Computer Service</u>		<u>3,480</u>						
<u>See Supplemental Schedule</u>			<u>43,728</u>						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$ <u> </u>			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ <u>124,189</u>						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.

STATE OF ILLINOIS

0031971

Report Period Beginning:

01/01/03

Ending:

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12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. II Council on LTC - \$7,439
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,343 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 79,387
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,308 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0.00
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.